FH

# STATE OF WISCONSIN
## Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

HMO/171744

**PRELIMINARY RECITALS**

Pursuant to a petition filed February 01, 2016, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on March 15, 2016, at Sheboygan, Wisconsin.

The issues for determination are whether Petitioner's appeal is timely and if so, whether Petitioner meets the approval criteria for coverage of a microprocessor leg prosthetic with elevated vacuum socket system, at a cost of $84,962.97, of which $34,600.81 is allowable.

NOTE: The record was held open until March 16, 2016, to give Petitioner's representative an opportunity to supplement the record. Petitioner's representative submitted a six-page fax containing a letter discussing the representative's conversation with the Petitioner and a lower limb prosthetic evaluation. The fax has been marked as Exhibit 2 and entered into the record.

On March 21, 2016, the Division of Hearings and Appeals received a letter from the Department of Health Services (DHS), indicating that it did not have enough information to determine whether coverage of the requested prosthetic could be approved. Since DHS has not made a decision one way or another, its letter has not been entered into the record.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

ADMINISTRATIVE LAW JUDGE:
Mayumi M. Ishii
Division of Hearings and Appeals

## FINDINGS OF FACT

1. Petitioner is a resident of Sheboygan County.
2. Petitioner is 27 years old. Her left leg was amputated at/above the knee, due to complications of injuries suffered in a car accident. (Exhibit 1)
3. Petitioner currently ambulates with her old prosthesis and a crutch. (Exhibit 1)
4. When Petitioner received her last prosthetic, which was a more basic prosthetic, it was comfortable and she was able to ambulate without the assistance of a crutch. (Exhibit 2; testimony of [redacted])
5. The insert for the prosthetic is two years old and worn out. The Petitioner has reported concerns about the stability of the knee in her old prosthetic. (Exhibit 2)
6. On October 27, 2015, [redacted] ([redacted]) submitted, on behalf of Petitioner, a request for authorization of a new prosthetic with a micro-processor knee, at a cost of $34,600.81. (Exhibit 1)
7. On November 25, 2015, the Petitioner's HMO, [redacted], denied coverage of the requested prosthetic. (Exhibit 1)
8. The Petitioner filed a request for fair hearing that was received by the Division of Hearings and Appeals on February 1, 2016. (Exhibit 1)

## DISCUSSION

A hearing officer can only hear cases on the merits if there is jurisdiction to do so. There is no jurisdiction if a hearing request is untimely. An appeal of a negative action by a county agency or HMO concerning medical assistance must be filed within 45 days of the date of the action. Wisconsin Stat. § 49.45(5); Income Maintenance Manual § 3.3.1. A negative action can be the denial of an application, or as in this case the denial of coverage for a service.

[redacted] provided notice of its denial of coverage on November 25, 2015. This would place the 45 day deadline to file an appeal at January 9, 2016. However, the notice provided by [redacted] failed to advise the Petitioner of the 45 day appeal deadline. Because the notice of appeal rights was defective, I must find Petitioner's appeal timely.

When determining whether to approve coverage of a service or medical equipment, the Medicaid program must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, §DHS 107.02(3)(e)*:

> (e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:
>
> 1. The medical necessity of the service;
> 2. The appropriateness of the service;
> *3. The cost of the service;*
> 4. The frequency of furnishing the service;
> 5. The quality and timeliness of the service;
> *6. The extent to which less expensive alternative services are available;*
> 7. The effective and appropriate use of available services;
> 8. The misutilization practices of providers and recipients;
> 9. *The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines;*

10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

*Emphasis added*

"Medically necessary" means a medical assistance service under ch. DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. *Is not solely for the convenience of the recipient, the recipient's family, or a provider*;
8. *With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and*
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

*Emphasis added; Wis. Admin. Code, §DHS 101.03(96m).*

As with most public assistance benefits the initial burden of demonstrating eligibility for any particular benefit falls on the applicant. *Gonwa v. Department of Health and Family Services,* 2003 WI App 152, 265 Wis.2d 913, 668 N.W.2d 122 (Ct.App. 2003) In other words, it is a Petitioner's burden to demonstrate that she meets the approval criteria for the requested prosthetic. It is not the Department's burden to prove that she is not eligible.

Further, I note that Medicaid is meant to provide the most basic and necessary health care services at a reasonable cost to a large number of persons and must authorize services according to the Wisconsin Administrative Code definition of medical necessity and other review criteria noted above. It is not enough to demonstrate a benefit; rather, all of the tests cited above must be met.

In the case at hand, Petitioner seeks coverage of a microprocessor leg prosthetic with elevated vacuum socket system, at a cost of $84,962.97, of which $34,600.81 is allowable.

According to the testimony of [redacted], the Petitioner's old prosthetic was comfortable and she was able to ambulate without the assistance of crutches. Coverage of a $34,600.81 - $84,962.97 computerized prosthetic is not cost-effective, when the Petitioner appears to have been able to function adequately with her former prosthetic.

[redacted] testified that the Petitioner requires an upgraded prosthetic so she can keep up with her 8 and 9 year-old children and because she would like to return to work as a package handler for a shipping company. (See also Exhibit 2) However, under *Wis. Admin. Code, §DHS 101.03(96m),* the requested service or good cannot be for the convenience of the recipient or recipient's family. Further, the Petitioner

indicated to [redacted] that she is not sure she wants to return to work, because she is contemplating returning to school. (See Exhibit 2)

The records indicate that the Petitioner does not have confidence in the knee of her current prosthetic. However, there is no medical documentation showing that the Petitioner has fallen due to a defect in or disrepair to her current prosthetic. Nor, is there any evidence that the knee joint is faulty.

Because there is insufficient evidence that the Petitioner is unable to function with the type/model of prosthetic she currently has, and because it appears that the upgraded prosthetic is more of a convenience than a necessity for the Petitioner, it is found that the requested prosthetic is not medically necessary, as that is defined in *Wis. Admin. Code, §DHS 101.03(96m)*, above.

I note that while the on-line provider handbook published by the Wisconsin Department of Health Services does not have specific approval criteria for microprocessor prosthetics, beyond the administrative code cited above, the Center for Medicare and Medicaid has established some approval criteria for microprocessor prosthetics at: http://www.medicarenhic.com/viewdoc.aspx?id=1649 . Below are some of the approval criteria:

> A lower limb prosthesis is covered when the beneficiary:
>
> 1. Will reach or maintain a defined functional state within a reasonable period of time; and
> 2. Is motivated to ambulate.
>
> …
>
> The records must document the beneficiary's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.
>
> …
>
> L5859 (ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION / EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)) is only covered when the beneficiary meets all of the criteria below:
>
> 1. Has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee
> 2. K3 functional level only
> 3. Weight greater than 110 lbs and less than 275 lbs
> 4. Has a documented co-morbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs K-3 level function with the use of a microprocessor-controlled knee alone
> 5. Is able to make use of a product that requires daily charging
> 6. Is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.

The prior authorization request lacks information comparing her current functional state to her expected functional state. In addition, the medical records lack information regarding the Petitioner's weight and it

is unclear whether the Petitioner would be able to manage the technology involved with a prosthetic that uses a microprocessor. Thus, for those reasons, also, authorization for the requested prosthetic must be denied.

Petitioner should note that [redacted] can, at any time, submit a new prior authorization request, with the necessary information.

## CONCLUSIONS OF LAW

The Petitioner has not met her burden to prove that she meets the approval criteria for a microprocessor prosthetic.

**THEREFORE, it is** **ORDERED**

That the petition is dismissed.

**REQUEST FOR A REHEARING**

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

**APPEAL TO COURT**

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 6th day of April, 2016

\sMayumi M. Ishii
Administrative Law Judge
Division of Hearings and Appeals

**State of Wisconsin\DIVISION OF HEARINGS AND APPEALS**

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The preceding decision was sent to the following parties on April 6, 2016.

Division of Health Care Access and Accountability
[redacted]